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September 28, 2011

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madame Secretary:

On behalf of the State of Nevada's Healthcare Reform Planning Group, we write to comment on proposed rules pertaining to the Establishment of Exchanges and Qualified Health Plans (QHPs), which were published in the Federal Register on July 15, 2011 in accordance with Title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act (ACA).

We appreciate the opportunity to comment on these important regulations. As detailed below, we have several suggestions on ways in which we believe the regulations can be improved to help ensure that onerous burdens are not placed on States as we establish and operate Health Insurance Exchanges ("Exchanges"). We believe that flexibility is crucial to the ultimate implementation of the ACA and the establishment of State-funded and State-administered Exchanges.

Overview

We believe that in many respects the proposed regulations are overly-prescriptive, particularly given the implementation timeline, the deadlines that States face in establishing Exchanges and expanding Medicaid, as well as all of the other policy and regulatory changes that must be completed over the next two years. We do not believe the statute provides justification for the stipulation of all of the terms and conditions that are incorporated within these – and other – proposed regulations. We urge you to revisit many of the requirements in these proposed rules with an eye toward providing as much flexibility as possible to States in the establishment and operations of State-funded and State-administered Exchanges.

Rather than specify the operational details in rule, we suggest that you provide general standards or templates that may be utilized by the State-administered Exchanges, in keeping with both the intent and spirit of the ACA. In recognition of the partnership approach to implementing the sweeping changes of the ACA, upon establishment of the various services and functions of a State-administered Exchange, the applicable federal agency could then review the State's approach and work with each State to modify the implementation plan, as appropriate.

Listed below are our comments, which are grouped under the following categories:

1. HHS Review and Approval
2. Entities Eligible to Carry Out Exchange Functions
3. Conflict of Interest
4. Navigators
5. Individual Exchange Application Process
6. Enrollment Process
7. SHOP Employer Participation Rates
8. SHOP Premium Billing, Collection and Remittance
9. SHOP Notice Requirements
10. SHOP Enrollment Process
11. SHOP Application Process
12. Multi-State Plans
13. QHP Certification
14. Provider Network Adequacy
15. Deceptive Marketing
16. Essential Community Providers
17. Premium Tiers
18. Termination for Nonpayment

We appreciate the opportunity to offer these comments, and look forward to working with you further on these and other health care reform implementation activities.

HHS Review and Approval of State-Administered Exchange Activities

Since the State-based Exchanges will need to be self-sustaining after 2014, it does not seem appropriate that CMS or HHS should have any involvement in changes implemented by State administered Exchanges. We disagree that CMS or HHS should maintain review and approval authority over operational changes made within the Exchange. States have been advocating for years to move away from the onerous and time-consuming State plan amendment process associated with both Medicaid and CHIP. To propose such a process for the Exchange will be very problematic, and Nevada would oppose such an approach.

Nevada would be supportive of a process that limits HHS approvals to significant changes in the Exchange plan, and utilizes an expedited process for review and approval of such changes. A tiered approval approach similar to that approved by HHS in the Rhode Island Global Medicaid Waiver is one alternative that may be worthy of consideration. Under this waiver, the State is not required to submit Medicaid or CHIP State plan amendments for changes that are

administrative in nature. Significant State plan changes, such as those affecting benefits, go through an expedited review and approval process.

Entities Eligible to Carry out Exchange Functions
We believe that some State agencies, such as a State Insurance Agency, may have the requisite knowledge and experience to carry out some of the functions of the Exchange. We request that you expand the list of eligible entities included in § 155.110 to include other State agencies.

Conflict of Interest
States generally have their own conflict of interest standards associated with the operation of public entities or publicly funded entities. We recommend that the regulations require explicit Exchange-based conflict of interest standards only if the laws and regulations of a State that chooses to administer a State-based Exchange do not include appropriate conflict of interest standards.

Navigators
The Navigator requirements (155.210) would require State governments to fund Navigators' activities prior to the Exchange becoming fully operational. We recognize the need to undertake comprehensive and multi-pronged outreach, education and enrollment, particularly during the initial open enrollment period in order to attract a broad and diverse risk pool. However, we are very concerned about the apparent requirement to fund the navigator program with State funds. In light of the fact that Exchanges will likely not be able to assess and collect revenues before participants are actually enrolled, the preamble statement that State Exchanges should use operational funds for this purpose is not realistic. Without federal funding, the Navigator funding requirements are essentially unfunded mandates.

In addition, we suggest that the regulations clarify that user fees remitted to the Exchange by insurers may be used to finance Navigator activities without violating the federal law. We also believe that the requirements that the State fund particular types of Navigators are neither appropriate nor supported by the statutory language.

General Standards for Exchange Notices
§155.23(c) indicates that the Exchange must consult with HHS when making changes to applications, forms and notices. We are concerned that the consultation process may slow down implementation of normal Exchange functions and urge you to allow States to file revised applications, forms and notices with HHS on an informational basis only.

Individual Exchange Application Process
We suggest that the language included in the final regulations should not be overly restrictive. In order to effectively implement the risk adjustment functions described in the companion package of proposed rules, State Exchanges may wish to administer or allow issuers of QHPs to administer medical questionnaires to enrollees. Additionally, the State Exchange may wish to adopt a requirement for members to complete a health risk assessment as part of the enrollment process. Limiting the amount of information collected at the point of enrollment could adversely affect the ability of the Exchange to best serve Nevadans, many of whom will become newly insured, and may restrict our ability to support a range of public health initiatives.

Enrollment Process
With regard to the enrollment process (155.410), we suggest that enrollments completed and received by the 22nd of the month preceding the effective date of coverage may not provide the Exchange – and more importantly, the QHP issuers – with sufficient time to process enrollment in time for an effective date of coverage of the first date of the following month. This may be a particularly acute problem during the first year of operations, when there is the potential for hundreds of thousands of Nevadans to sign up for coverage, both through the Exchange and in health plans available outside the Exchange.

You requested comments as to whether the federal regulations should prescribe standards for effective dates of coverage, required dates of notices, dates of open enrollments for plan years after 2014, and managing transfers of members following plan mergers. We suggest that final regulations should defer to State Exchanges on these and other operational details, providing more general guidelines instead of prescribing specifics.

As noted above, we are concerned that overly-restrictive limitations on the information collected as part of the application process and at the point of enrollment may limit the State's ability to connect disparate data sources and reduce verification requirements on applicants – and/or to conduct the types of screening that we describe above.

SHOP Employer Participation Rates
With regard to participation rate requirements, we believe that State Exchanges should determine whether, and how, to set participation and/or contribution requirements. We believe that providing flexibility to Exchanges in this regard is critical to address State-specific circumstances particularly in the small group markets.

SHOP Premium Billing, Collection and Remittance
The requirement at 155.705(b)(4) that State Exchanges collect all SHOP premiums may have unintended consequences. In the event that an employer selects a single QHP as permitted under 155.705(b)(2), the Exchange should allow the issuer to bill the employer directly. This is an example of our larger concern that the proposed rules are overly prescriptive in nature. We suggest that the regulations should allow employers to choose to be billed directly by the issuer or have the premiums collected by the SHOP Exchange and then remitted to the issuers.

SHOP Notice Requirements
With respect to the notices that may be required under 155.715(g), we are concerned that these may duplicate COBRA and mini-COBRA notices, and that the differences in these notices may ultimately prove confusing to recipients. For this reason, we urge you to adopt a COBRA notice specific to employers in the SHOP Exchange; States may adopt the same text for their mini-COBRA notice requirements, and the Exchanges may elect to use this or a related text for its notice. In this way, we may be able to reduce the disparate types of notices that an employee receives.

With regard to disenrollment notification requirements at 155.720(h), we suggest that the regulations allow State Exchanges to require all disenrollment requests from current employees to be submitted directly to the participating employers. In this way, the Exchange can ensure

that the employer receives notification and that the employer is able to communicate to the employee the potential consequences of disenrollment.

SHOP Enrollment Process
Regarding the proposed open enrollment dates at 155.725(e), we suggest that the regulations allow State SHOP Exchanges to determine the open enrollment dates.

SHOP Application Process
With regard to the application data requirements described in 155.730(b), we suggest that State Exchanges should retain the ability to request additional data fields and identifying information that may make it easier to link the employer (and the employees) to other data sources in the State. Regarding the broad prohibition on the SHOP Exchange requesting additional information from the applicant that may go above-and-beyond the information needed to complete an employee application, we suggest that the rules not impose limitations on the information that the SHOP Exchange may request of employees for the reasons that we make this request for the individual market Exchange.

Multi-State Plans
We are unclear about the federal interpretation of PPACA Section 1334(c) and the certification exemptions described at 76 FR 41891 and in the proposed rules at 155.1000(a) and 155.1010(b). The preamble comments indicate that multi-State plans must meet "all requirements for QHPs" but later states that multi-State plans are "deemed" as meeting the State Exchanges' certification requirements. We assume that this means that if a State Exchange adopts certification standard that go beyond those in the federal rules, then the multi-State plans would not need to comply with such standards. We oppose any federal interpretation that would potentially exempt multi-State plans from certification standards adopted by a State Exchange

We request clarification as to whether multi-State plans must also satisfy any and all requirements imposed on State-certified QHPs. We believe that any other approach will undermine the ability of State Exchanges to ensure market competition and a level playing field for all QHPs sold through the Exchanges.

QHP Certification
We respectfully disagree with the proposed rule at 155.1010(c) regarding the timing of QHP certification. We are unclear why such a strict, inflexible standard is needed. State Exchanges should retain the flexibility to allow new issuers of QHPs to enter the market in a manner that they deem appropriate for their State's market.

Provider Network Adequacy
We support the flexibility granted to State Exchanges in the proposed rule at 155.1050 regarding provider network adequacy standards. Standards should be determined locally, not imposed by federal standard. In response to the questions posed, we believe that any further federal regulatory action or guidance with regards to network adequacy should be limited to the provision of technical assistance.

Deceptive Marketing
Regarding the deceptive marketing practices discussion, we agree with the need for consumer protections. In Nevada, we will continue to rely on our Department of Business and Industry and the Division of Insurance to take the lead on this issue.

Essential Community Providers
We concur with the proposed provisions regarding the contracting requirements for essential community providers which provide maximum flexibility to State Exchanges in this regard. We urge you to defer to State Exchanges on the definition of the sufficient number of essential community providers required in the QHPs' networks.

Regarding the statutory inconsistency about FQHC payments as discussed at 76 FR 41899, we are unclear whether FQHCs have the statutory right to demand that QHP issuers reimburse them under the PPS methodology -- or whether a QHP issuer could insist on a different methodology. Given the emphasis in the ACA around payment innovation and the flexibility in the essential community provider contracting standards, we think it is appropriate to adopt a simple rule that the issuer must simply pay an FQHC an amount that is roughly commensurate (but not precisely equal or great than) to the issuer's generally applicable payment rates. Consistent with our preference for market-based solutions, we feel that FQHCs should receive payment rates reflecting the general willingness of qualified providers in an area to provide the same service to the same population.

Premium Tiers
With respect to the proposed premium tier structure (i.e., individual, two adults, adult plus child or children, and family coverage), we are unclear why it is necessary for federal regulations to include this level of operational detail. Rather, we suggest that State Exchanges and the State insurance regulators (e.g., Nevada Division of Insurance) should define the tiers in a way that they deem appropriate. Because the rates will be generated by the Exchange and appear to the consumer without reference to tiers, the consumer would be largely indifferent to the approach chosen.

Termination for Nonpayment
We are extremely concerned with regard to the premium grace period and related procedures (156.270), and we believe that this will make the Exchange less attractive to higher-income adults in States that have comparatively low household incomes. In short, issuers will have to compensate for their estimate of delinquent or foregone premiums from such enrollees during these grace periods by increasing the base premium rates for all enrollees. Individuals that receive advance payments of tax credits will be insensitive to these increases – but those that do not will have to pay higher premiums either (a) in the Exchange or (b) in the non-Exchange market if they purchase QHPs from issuers that also sell on the Exchange. For this reason, we believe that the impact of delinquent or foregone enrollee premiums should be minimized by allowing State Exchanges and QHP issuers to refuse the following for enrollees during the period of delinquent payment status:

(a) prior authorizations for all non-emergent outpatient and inpatient services;
(b) electoral procedures;

(c) non-emergent out-of-network services;
(d) prescription drugs; and
(e) additions of new household members.

State Exchanges should be able to allow QHP issuers to reverse claims for such members during the grace period if the member is ultimately terminated for non-payment of premiums. Thus, health care providers would be able to pursue such individuals for the costs of services rendered.

We are also unclear as to how to interpret a clause in 156.270(f). The provision allows QHPs to terminate coverage for an enrollee if the enrollee "...exhausts the grace period...without submitting any premium payment...." Does this mean that an enrollee can submit a partial payment or nominal amount to avoid termination at the end of the grace period? State Exchanges and QHPs should have the right to insist on full payment of delinquent enrollee premiums before continuing coverage.

We are unclear on how to interpret the preamble comment that "QHP issuers must apply non-payment of premium policies, irrespective of Exchange standards, uniformly to all enrollees in similar circumstances." Does this mean that QHP issuers must apply the same non-payment policies to enrollees who do not receive advance premium tax credits? Likewise, must QHPs in the parallel market (outside of the Exchange) apply these non-payment policies to their enrollees?

Rate Review

In response to the request for comment regarding a bifurcated process for a rate increase justification, we suggest that the final regulation recognize the decisions made by a State's insurance department regarding the review of rates and not require the Exchange to develop a separate rate review process. We believe that additional review will be unnecessary and costly.

We appreciate the opportunity to comment on these proposed regulations and look forward to working with you on the implementation of a Health Insurance Exchange that works for the residents, businesses and health insurers of Nevada.

Sincerely,

Michael J. Willden
Director of Health and Human Services
Acting Executive Director, Silver State Health Insurance Exchange

cc: Ann Wilkinson, Deputy Chief of Staff, Office of the Governor
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